



C&RCFD REV 061 7/04

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH CARE REGULATION AND LICENSING ADMINISTRATION**



CHILD & RESIDENTIAL
CARE FACILITIES
DIVISION
Phone: (202) 442-5929
Fax: (202) 442-9430

MAILING ADDRESS:
825 North Capitol Street, NE
Second Floor
Washington, DC 20002

EMERGENCY CONTINGENCY PLAN

1. In the event of emergency closure, due to any reason that will prohibit the facility from caring for the children temporarily the following plan will be in effect:

CONTACT PERSON:

Name of Provider: _____

Address: _____

Telephone: _____ Pager: _____

Cell Phone: _____ Fax: _____

2. The Department of Health, Department of Human Services/Office of Early Childhood Development (OECD) if applicable, and parents/guardians will be notified immediately by telephone and in writing.

3. The children will be relocated to the following location: (If more than one (1) location is used please indicate on the back and check this block:) ☐

Emergency Provider's Name: _____

Address: _____

Telephone: _____ Pager: _____

Cell Phone: _____ Fax: _____

4. The children will be transported by:

☐ Foot ☐ Bus ☐ Car/Van ☐ Other _____

Any cost involved in transporting the children will be paid by:

☐ Provider ☐ Parent ☐ Not applicable

5. In the event of emergency closure due to any reason that will prohibit the facility from caring for the children permanently, the children will be referred to other licensed child development facilities.

Signature of Provider

Date

6. I have read this agreement and grant the provider named above permission to use my facility in case of emergency evacuation of the provider's facility.

Signature of Emergency Provider

Date

PLEASE RETAIN A COPY RETAIN FOR YOUR RECORDS